Financial Services Commission of Ontario

Ontario

Commission des services financiers de l'Ontario

Appeal P10-00005

OFFICE OF THE DIRECTOR OF ARBITRATIONS

Mrs. S

Appellant

and

ECONOMICAL MUTUAL INSURANCE COMPANY

Respondent

BEFORE:	Delegate Lawrence Blackman
REPRESENTATIVES:	Mr. Michael Rubin for the Appellant, Mrs. S Mr. Nicholaus de Koning for the Respondent, Economical Mutual Insurance Company
HEARING DATE:	November 8, 2010

APPEAL ORDER

Under section 283 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. The Arbitrator's order dated February 12, 2010 is confirmed and this appeal is dismissed.

2. If the parties are unable to agree on the legal expenses of this appeal, an expense hearing shall be requested within thirty days of the date of this decision. The request shall be accompanied by a Bill of Costs describing the expenses claimed, services received and the costs, as well as submissions regarding entitlement to and/or the quantum of such expenses.

November 17, 2010

Lawrence Blackman
Director's Delegate

Date

REASONS FOR DECISION

I. BACKGROUND AND NATURE OF THE APPEAL

As a result of being injured in a November 22, 2006 motor vehicle accident, the Appellant, Mrs. S, applied to the Respondent, Economical Mutual Insurance Company, for first-party automobile accident benefits payable under the *Schedule*.[1] The Respondent, while paying certain benefits, refused payment of weekly income replacement benefits ("IRBs") and housekeeping expenses. In part, the Respondent was not satisfied with the Appellant's representation that she had worked in the three months prior to the accident.

Mediation having failed to resolve the issues in dispute, the Appellant filed for arbitration at the Financial Services Commission. The parties came before Arbitrator Renahan (the "Arbitrator") in a November 2009 hearing. In his February 12, 2010 decision, the Arbitrator found that the Appellant was not entitled to the IRBs and housekeeping benefits claimed. He further dismissed the Appellant's claim for a special award advanced under subsection 282(10) of the *Insurance Act*, R.S.O. 1990, c. I.8. The Arbitrator deferred the question of arbitration legal expenses.

The Arbitrator found that the Appellant's evidence regarding her alleged employment was not believable and that she had made up the story. He further found the Appellant not entitled to housekeeping expenses as the claim was inconsistent and lacked any believable detail.

II. THE APPELLANT'S SUBMISSIONS

The Appellant's March 11, 2010 Notice of Appeal asked that the Arbitrator's decision be set aside and an order be substituted that she was entitled to the IRBs and housekeeping benefits claimed, as well as interest, a special award and her legal expenses at arbitration and on appeal. The Appellant asked that the Arbitrator's expense order be stayed on the basis that a global assessment of costs should be made after the appeal was determined.

[1] *The Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996,* Ontario Regulation 403/96, as amended.

The Appellant argued that the Arbitrator had erred in law in determining that the Respondent's failure to meet, by 15 days, the *Schedule's* subsection 32(6) time line within which to determine her entitlement and pay the benefits claimed was only a procedural irregularity. Rather, the Arbitrator should have deemed the full benefits claimed payable and granted a special award. In the alternative, the Appellant submitted that the Respondent was liable to pay her IRBs and housekeeping expenses at least until the date the Respondent had responded to her Application for Accident Benefits by requesting further documentation and investigation.

In oral submissions, however, the Appellant conceded that the Arbitrator's findings of fact resulted in her not being entitled to the principal of the benefits claimed. Even if the benefits had been ordered paid on the basis of the Respondent's non-compliance with the *Schedule*, they would be subject to repayment under section 47 of the *Schedule*. However, the Appellant argued that she was still entitled to the accrued interest on the unpaid benefits as interest was not a benefit and, hence, not subject to repayment under section 47.

In the case of housekeeping benefits, the accrued interest on two years, or $10,400, of benefits was $10,338.34. The interest on IRBs was as much as $49,355.74, if the date to which the benefits should have been paid was the Arbitrator's February 12, 2010 decision.

The Appellant relied on the Supreme Court of Canada's enunciation in *Smith v. Co-operators General Insurance Co.*, [2002] 2 S.C.R 129, that the *Schedule* is consumer protection. In light of this legislative goal, it was necessary to consider the potential consequences to claimants if an insurer is not held to strict compliance with the *Schedule*.

The Appellant provided hypothetical situations where an insured was eligible for weekly IRBs, had limited economic resources but rental or mortgage obligations. If IRBs were not paid within the statutory timelines, an insured who was renting could be evicted and made homeless. An insured who was a mortgagor could be subject to a monetary penalty or the loss of their home.

The Appellant submitted that neither a special award nor interest can compensate for the loss of one's home, credit rating or self-esteem. Relying on the Ontario Court of Appeal decision in *Bapoo v. Co-operators General Insurance Co.*, 36 O.R. (3d) 616, the Appellant argued that one

must look at the most just and reasonable interpretation of the *Schedule*. The Appellant noted that the Court agreed with the proposition that "[s]tatutory interpretation should not be dependent upon the situation of the particular litigant."

This meant, the Appellant submitted, that each case must be looked at separately, not claimant by claimant, but insurer failure by insurer failure. Although the Appellant herself was not the ideal applicant, that was irrelevant. An insurer's obligation to pay was based not on a claimant's entitlement, but on its own obligation to pay, to use the words of in *Smith*, "without undue solicitude for particular circumstances that might operate against claimants in certain cases."

The Appellant proposed a four-part test regarding an insurer's non-compliance with its obligations under the *Schedule*. In the Appellant's words, "my test has nothing to do with entitlement, it has everything to do with obligation."

Applied to this case, the Appellant submitted that firstly, subsection 35(3) of the *Schedule*, by use of the mandatory word "shall," rendered a benefit payable 10 business days after the insurer received the application for IRBs and the completed disability certificate, regardless of entitlement. The insurer, however, under the second part of the proposed test, would be exempt from payment if it sent a request under subsections 33(1) or (1.1) seeking additional information or notified the insured that it required a medical examination under section 42 of the *Schedule*.

The third part of the proposed test in this case was that the Respondent did not comply with the time lines to pay or to exercise the available exemptions either under subsection 35(3) or the extended time lines of subsection 32(6). The latter was applicable as the Applicant had failed, by several months and without a reasonable excuse, to notify the Respondent of her intention to apply for a benefit within the requisite subsection 32(1.1) time period.

The fourth and final step was that as the Respondent was some 15 days late in responding to the application for benefits, the Appellant's claim was automatically payable without any consideration of her actual entitlement. The Respondent, however, had a subsequent right to claim repayment of benefits, but not interest, under section 47 of the *Schedule* on the basis of error, willful misrepresentation, fraud or the other enumerated grounds.

This analysis, it was submitted, was just and fair because there were significant repercussions if an insurer erred, but with a built-in right for repayment to an insurer of any principal amount. This was not a windfall for an insured person, but rather an incentive to insurers to comply, in a timely manner, with their obligations under the *Schedule*.

The implication of this argument would be that if an insurer immediately accepted that the result of its non-compliance was payment of the benefits claimed, it would not be subject to any interest payment. Insurers, the Appellant submitted, should not be able to retroactively deny benefits and then hope that there was a later entitlement decision by an adjudicator that "let them off the hook." This was especially important in the context of section 35 that addressed IRBs, a benefit that is particularly crucial for insured persons. However, the Appellant stated that she was unable to find any case law directly in support of her analysis.

The Appellant also submitted that the Arbitrator had erred in law in failing to determine that subsection 64.1(1) of the *Schedule* did not apply to her. This provision provides that if legislation requires a person to report his or her income, a claimant's income shall be determined without reference to any income the person failed to report contrary to that legislation.

The Appellant argued, in part, that her alleged employment in the three months pre-accident totaled $6,875, which was insufficient to merit taxation. Accordingly, the Appellant submitted that she was excluded from reporting this income under subclause 150(1.1)(b)(i) of the *Income Tax Act*, R.S.C. 1985, c. 1 (5th Supp.).

III. THE RESPONDENT'S SUBMISSIONS

The Respondent accepts that this Appeal raises questions of legal interpretation. However, the interpretations argued by the Appellant are unreasonable. The Respondent also submitted that the Appellant's stay request was premature.

The Respondent submitted that the parties agreed that as the Appellant did not notify the Respondent, as required, within seven days of the accident of her intention to apply for a benefit, the Respondent was entitled to delay determining entitlement until 45 days after receipt of the

application. The Arbitrator found that the 45th day was May 21, 2007. On June 2, 2007, the Respondent advised the Appellant it was arranging medical examinations under section 42 of the *Schedule*. On June 7, 2007, pursuant to section 33, it requested further documentation.

While acknowledging that the time lines under the *Schedule* are important and that prompt payment of benefits is a theme of the *Schedule* and of the case law, the Respondent disagreed that a technical breach of subsection 32(6) by 15 days created entitlement to a benefit without any further inquiry into whether the Appellant met the substantive eligibility and disability criteria for such benefits.

Firstly, it was argued that clause 32(6)(a) of the *Schedule* does not impose specific consequences for an insurer's non-compliance with the 45-day time line. Further, there are no decided cases establishing that an insurer's failure to comply with subsections 32(6) or 35(3) created substantive benefit entitlement for an insured otherwise found not to meet the eligibility criteria for those benefits. If the consequences of non-compliance by an insurer were those argued by the Appellant, the Legislature would have provided more explicit language.

The Respondent submitted that cases such as *Pintucci and Jevco Insurance Company*, (FSCO A97-000755, January 7, 1999), relied upon by the Appellant in her written submissions, were of little or no relevance, as they pertained to an earlier version of the *Schedule* that clearly required an insurer to continue paying for treatment pending resolution of an entitlement dispute. In any event, even in *Pintucci* the adjudicator noted that the case before her was not one where a serious question of fraud had been raised or where the claim was clearly unreasonable.

Rather, the Respondent cited decisions where, it submitted, adjudicators had exercised caution in determining the consequences of an insurer's technical breach of the *Schedule*. *Galati and Aviva Canada Inc.*, (FSCO A04-001256, August 19, 2005), it was submitted, held that it would be unfair to essentially award an insured person one hundred percent of a claim at a preliminary stage, without any evidence as to the merits of that claim, based on an insurer's technical error.

Seyed and Federation Insurance Company of Canada, (FSCO A07-002110, June 8, 2009), it was argued, held that there were remedies for an insurer's breaches other than allowing a windfall to

a person who might not otherwise be entitled to the benefits claimed and that it would be tantamount to an abuse of process for a person who deliberately and repeatedly tried to mislead an insurer to gain an advantage by relying upon a technical deficiency in the handling of the file.

The Respondent also cited *Gray v. Pilot Insurance Company*, 2006 CanLII 22118 (ON S.C.), for the proposition that a technical breach by an insurer in missing time lines in the *Schedule* did not create substantive benefit entitlement unless the *Schedule* specifically so provided.

Rather, the remedy for an insurer's non-compliance with the *Schedule* would be interest at two per cent a month, compounded monthly, under section 46 of the *Schedule*, a possible special award or the imposition of legal expenses, the conduct of a party being a relevant criterion under Rule 75.2 of the *Dispute Resolution Practice Code*, (Fourth Edition, Updated – September 2010) (the "*Code*").

Regarding the hypothetical illustrations provided by the Appellant, the Respondent submitted that it was conceded at arbitration that the Appellant was on social assistance both before and after the accident. As the Arbitrator found that the Appellant was not employed, the Appellant had not suffered any loss of income or other prejudice. In essence, the Respondent argued that if the Appellant's arguments were accepted, this would not merely allow a windfall from a technical error, but would be countenancing fraud.

As to section 64.1 of the *Schedule*, the Respondent accepted that while the Appellant may not have been required to file a tax return for 2006, she was still obliged to have been truthful when she, nonetheless, did file her return. As the Appellant's purported income was not included in her 2006 income tax return, her IRB, based on section 64.1, would be nil. In any event, as the Arbitrator found that the Appellant had falsified her employment and was not employed, this issue was academic and moot.

The Respondent concluded that the Appellant did not come to this appeal with clean hands and should not be allowed to take advantage of a technical breach or error on the Respondent's part that, as found by the Arbitrator, did not prejudice the Appellant. Accordingly, the appeal should be dismissed.

IV. ANALYSIS

By letter decision dated April 12, 2010, I declined to stay the Arbitrator's order respecting legal costs. I had no jurisdiction to usurp the authority of the Arbitrator by determining, at first instance, arbitration expenses. I thus left it to the Arbitrator to decide the procedure and timing for determining such expenses. The Arbitrator subsequently issued his expense decision on May 31, 2010, finding that the Respondent was entitled to its arbitration expenses, the amount to be agreed or assessed. This decision was not raised in submissions before me.

Turning to the substance of the appeal, the Arbitrator found that the Appellant was involved in a November 22, 2006 accident. Clause 32(1.1)(b) of the *Schedule* required the Appellant to notify the Respondent of her intention to apply for a benefit no later than the seventh day after the circumstances arose giving rise to the entitlement to the benefit, or as soon as practicable thereafter. The Arbitrator found that the Respondent was first notified of the accident on March 12, 2007, when it received an Application for Approval of an In-Home Assessment, which the Respondent approved.

The Arbitrator found that the Respondent received the Appellant's Application for Accident Benefits on April 5, 2007. The Application included an IRB claim. Subsection 35(3) of the *Schedule* provides that with regard to IRB and housekeeping claims, amongst others:

> (3) Within 10 business days after the insurer receives the application and completed disability certificate, the insurer shall,
>
> (a) pay the specified benefit;
>
> (b) send a request to the insured person under subsection 33 (1) or (1.1); or
>
> (c) notify the insured person that the insurer requires the insured person to be examined under section 42. O. Reg. 546/05, s. 9.

It is not disputed that the Appellant failed, without a reasonable explanation, to notify the Respondent within the time required under subsection 32(1). Accordingly, the Arbitrator found, pursuant to subsection 32(6) of the *Schedule*, that the Respondent could delay determining

whether the Appellant was entitled to benefits for 45 days, in this case, until May 21, 2007. Subsection 32(6) of the *Schedule* provides that:

> (6) Despite any shorter time limit in this Regulation, if a person fails without a reasonable explanation to notify an insurer under subsection (1) within the time required under subsection (1.1), the insurer may delay determining if the person is entitled to a benefit under section 35, 38, 39 or 41 and may delay paying the benefit until the later of,
>
> (a) 45 days after the day the insurer receives the person's application; or
>
> (b) 10 business days after the day the person complies with any request made by the insurer under subsection 33 (1) or (1.1).

The Arbitrator noted that the Respondent admitted that it missed the subsection 32(6) deadline by about 15 days, waiting until June 2, 2007 to advise the Appellant that it was setting up medical examinations to determine her IRBs and housekeeping eligibility and until June 7, 2007 to advise that it required, pursuant to section 33 of the *Schedule*, the employer's file.

These findings are not appealed. Indeed, subsection 283(1) of the *Insurance Act* limits appeals from the order of an arbitrator to questions of law.

The *Schedule* is not precisely tailored to every specific circumstance of individual claimants. Unlike tort compensation, it is, to a significant degree, "off the rack" legislation. Further, its provisions are a compromise between sometimes competing legislative goals, including providing a fair yet limited degree of compensation, being a payer of last resort yet representing a trade-off for statutory limitations on accident victims' third-party tort recovery, paying claims on the principles of no-fault and consumer protection in a timely manner, yet avoiding double recovery and preventing fraud or abuse of the system.

The legislation does, however, provide a measure of clear, specific adjudicative discretion to smooth the perhaps sometimes rougher edges of the legislation, in appropriate circumstances. These measures include, under the *Insurance Act*, subsection 282(10) special awards where an insurer is found to have unreasonably withheld or delayed payments, subsection 279(4.1) interim benefits orders and expense awards under subsections 282(11) to (14).

The Arbitrator, however, also cited the following from *Gray*:

> The SABS is silent as to the consequences of missing the timelines set out therein. The SABS imposes no sanctions for failure to meet the timelines. There is nothing in the Schedule to suggest that failure to adhere to the 30 day period, for example, results in a claimant being deemed to be catastrophically impaired.
>
> Timelines are important for the purpose to ensure that claims are dealt with expeditiously.
>
> Errors, however, will inevitably occur. Whether they amount to mere procedural irregularities which should be relieved against, or matters of substance, must depend on the circumstances of each case.

The Arbitrator found the Respondent's 15-day delay in responding to the Appellant's application was a procedural irregularity that did not prejudice the Appellant and which was not a ground for awarding her the IRBs and housekeeping benefits sought.

In oral submissions, however, the Appellant did not argue that, based on *Gray*, the Arbitrator had erred in any exercise of discretion, for reasons that seem obvious. This was not a sympathetic case for the exercise of such discretion that might exist. The Appellant was months late in notifying the Respondent of her intention to apply for a benefit. The Arbitrator found that the Appellant was not employed at the time of the accident, as alleged, and that she had provided made-up evidence.

It would be difficult to argue it was an injustice or that discretion had been wrongly exercised in failing to find an insured automatically entitled to benefits, perhaps indefinitely, based on the Respondent missing its subsection 32(6) obligations by 15 days, where the Arbitrator found that the Appellant's evidence was implausible, not believable, made no sense, was inconsistent and lacked any believable detail.

Thus, the Appellant argued that subsection 35(3) of the *Schedule* requires, on its strict reading or as reasonably interpreted, that in all cases the insurer must be in complete compliance with that provision. Non-compliance, no matter how innocent the breach, no matter how faulty the claim, must automatically result, so as not to prejudice genuinely meritorious cases, in the payment of benefits, subject to a possible later repayment order of the principal, but not interest.

The first difficulty with this argument is that subsection 35(3) is not determinative in this case. Rather, subsection 32(6) applies, as the Appellant failed to meet her reporting obligation and did not provide a reasonable explanation. Subsection 32(6) states that the insurer "may delay determining if the person is entitled" to a specified benefit and "may delay paying the benefit" until the later of two time periods, the parties agreeing that the applicable period is 45 days after the Respondent received the Appellant's benefits application.

In *Vijeyekumar et al. v. State Farm Mutual Automobile Insurance Co.* (1999) 44 O.R. (3rd) 545, the Ontario Court of Appeal confirmed the presumption against tautology rule of statutory interpretation, "that the legislature is presumed to avoid unnecessary or meaningless language. Every word in a statute or regulation is to have a meaning and a function."

The subsection 32(6) time lines have a function in advancing the legislative purpose of timely compliance. The clear legislative remedy for non-compliance is mandatory interest and a discretionary special award. Specifically, subsection 46(1) of the *Schedule* that provides that:

> **46.** (1) An amount payable in respect of a benefit is overdue if the insurer fails to pay the benefit within the time required under this Part.

Sections 46, 32 and 35 are all in the same "Part" of the *Schedule*, namely "Part X." Failure by an insurer to meet its obligations within the 45-day time line in subsection 32(6) means that the benefits become overdue. The mandatory consequence of an amount being overdue is set out in subsection 46(2), namely:

> (2) If payment of a benefit under this Regulation is overdue, the insurer **shall** pay interest on the overdue amount for each day the amount is overdue from the date the amount became overdue at the rate of 2 per cent per month compounded monthly. [emphasis added]

A further possible consequence of a delayed payment is set out in subsection 282(10) of the *Insurance Act*, that provides that:

> (10) If the arbitrator finds that an insurer has unreasonably withheld or delayed payments, the arbitrator, in addition to awarding the benefits and interest to which an insured person is entitled under the *Statutory Accident Benefits Schedule*, shall award a lump sum of up to 50 per cent of the amount to which the

> person was entitled at the time of the award together with interest on all amounts then owing to the insured (including unpaid interest) at the rate of 2 per cent per month, compounded monthly, from the time the benefits first became payable under the *Schedule*.

The argued further mandatory consequence of an insurer not meeting the subsection 32(6) time line being the automatic payment of the benefits sought, regardless of the entitlement criteria, is an especially far reaching consequence. I am persuaded that if the Legislature had intended such a significant automatic result, with or without some measure of possible repayment, in addition to the clearly stated remedies as noted, it would have said so.

To find otherwise would also be inconsistent with the reasoning in the recent Ontario Court of Appeal decision in *Stranges v. Allstate Insurance Company of Canada*, 2010 ONCA 457, notwithstanding that the latter addressed a different section in a prior version of the *Schedule*. In *Stranges*, the Court held that:

> The inadequacy of the refusal notice did not entitle the respondent to payment of benefits in perpetuity until proper notice was given or a proper DAC assessment was carried out. The respondent was still required to prove that she was entitled to the continued payment of IRBs because of her continued substantial inability to perform the essential tasks of her employment.

Accordingly, this part of the appeal is dismissed. It is thus unnecessary to address whether, in light of the Ontario Court of Appeal decision in *Sorokin v. Wawanesa Mutual Insurance Company*, 2009 ONCA 152 (CanLII), interest under the *Schedule*, found to be compensatory rather than punitive and a benefit for the purposes of section 46, is also a benefit for the purposes of section 47 and, hence, also subject to repayment.

Turning to section 64.1(1) of the *Schedule*, the latter provides that:

> 64.1 (1) If, under the *Income Tax Act* (Canada) or legislation of another jurisdiction that imposes a tax calculated by reference to income, a person is required to report the amount of his or her income, the person's income before an accident that occurs after April 14, 2004 shall be determined for the purposes of this Regulation without reference to any income the person has failed to report contrary to that Act or legislation.

The Arbitrator, in his May 31, 2010 expense decision, found that section 64.1 had no application as he had found that the Appellant had not worked and, hence, had no obligation to file a tax return for income she did not earn. Having rejected the first part of the Appellant's appeal, this issue is moot.

In any event, to follow the logic of the Appellant's submissions, if an insured person is deemed obliged to receive the IRBs claimed regardless of whether the disability criteria are met, whether one was employed and whether the claim was simply fraudulent, it is not clear why the alleged failure to properly report one's income, fictional or otherwise, to Revenue Canada should make any difference.

Accordingly, this aspect of the appeal is also dismissed. In accordance with subsection 283(5) of the *Insurance Act*, the Arbitrator's February 12, 2010 decision is confirmed.

V. EXPENSES

If the parties are unable to agree on the legal expenses of this appeal, pursuant to Rule 79.2 of the *Code* an expense hearing shall be requested within thirty days of the date of this decision. The request shall be accompanied by a Bill of Costs describing the expenses claimed, services received and the costs, as well as submissions regarding entitlement to and/or the quantum of such expenses.

Lawrence Blackman Director's Delegate	November 17, 2010 Date